Quality Management Outcomes Team
Meeting Agenda
February 28, 2008 10:00 a.m. – 2:00 p.m.

held at

KY Department for Mental Health & Mental Retardation Services
100 Fair Oaks Lane, Frankfort

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Meeting Overview: The purpose of today's meeting is to discuss Department efforts to move the Evidence Based Practice agenda forward as well as Federal reporting requirements. Further, we'll have follow-up discussion on the group's idea of a toolkit for use in measuring functioning. Our chairperson will also address the use of the BPRS in mobile crisis units.

1. **Introductions – Welcome**

- The group welcomes a new participant.
  - Betsy Jackson joins the group representing Pathways; she is their new Quality Improvement Director since Glen Rowe's retirement.

WELCOME BETSY ☺

Previous Meeting Follow-Up:

- **GAF Score and its relevance to measuring client functioning** - FOLLOW-UP

  Some CMHC representatives suggested the need for a comparison / counter-balance measure to the self-reported functioning data collected on surveys. Is the "change in GAF score" an index worthy to track and analyze in a global sense? What will be the best measure of "improved Kentuckians"?

  Today, the group will briefly visit this topic to reach consensus on a direction for analyzing client functioning beyond the self-reporting surveys.
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2. Training / Discussion

- **Evidence Based Practices (EBPs)**
  - Lou Kurtz, KDMHMRS – Division of Mental Health & Substance Abuse, will start off this topic by providing an overview of the Department's efforts over the past two years to move evidence-based mental health practices forward. Further, Lou will introduce to us the idea of a "Kentucky Center of Excellence for Evidence Based Practices".
  - We'll then explore the Federal reporting requirements on EBPs. (Definitions are attached)
    This will include breakout groups to better address ten specific EBP reporting-requirements. The following chart is designed to guide this conversation.

    ✓ **CMHC agencies are invited to collaborate with your colleagues beforehand; further all are welcome to QMOT for this break-out session work. Particularly, we extend this to your colleagues who may fully contribute to this subject.**

Evidence Based Practice	Review Federal Definitions	List Current Efforts	List Barriers	List Contacts (who needs to involved)	Name Options for Collecting and Reporting
Supported Housing					
Supported Employment					
Assertive Community Treatme					
Therapeutic Foster Care					
Multi-Systemic Therapy					
Family Functional Therapy					
Family Psychoeducation					
Integrated Treatment for Co-occurring Disorders (MH/SA)					
Illness Self Management					
Medication Management					

Lunch break

3. Reducing Data Collections

- **BPRS related to Crisis Events**
  Donna will address the question brought before the group: Is the BPRS the best tool to use in measuring client "improvement" when treated by a mobile crisis unit?

- **Criminal Justice Arrest Data**: An update will be given on efforts to report arrests associated with clients receiving mental health services as federally required.

4. Updates

Members of the group are encouraged to share about current quality improvement efforts.

What QI/QA celebrations and challenges have you experienced recently?

5. Next: Meeting Schedule

Please check the QMOT web site for updated details on calendar events:
http://mhmr.ky.gov/cmhc/qmot.asp

The next meeting is:

April 24, 2008 (topics of interest: Witnesses of Domestic Violence data **)**

10:00 a.m. – 2:00 p.m. with a brief networking/lunch break.

LOCATION: downtown Frankfort – Transportation Cabinet's Conference Center room 107 – 200 Mero Street

Fiscal Year 2008 Meeting Schedule:
This group meets bimonthly 4th Thursday 10:00 a.m. – 2:00 p.m. with a brief lunch break

- **June 26, 2008**
- **August 28, 2008**
- **October 23, 2008**

ASSERTIVE COMMUNITY TREATMENT

I. DEFINITION

A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomized effectiveness studies in the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General, December, 1999, Chapter 4, "Adults and Mental Health, Service Delivery, Assertive Community Treatment"). Additionally, CMS (formerly HCFA) recommended that state Medicaid agencies consider adding the service to their State Plans in HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations, June 07, 1999.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/

III. MINIMUM REQUIREMENTS FOR REPORTING ACT

- Small caseload: Client/ provider ratio of 10:1 or fewer is the ideal.
- Multidisciplinary team approach: This is a team approach rather than an approach which emphasizes services by individual providers. The team should be multidisciplinary and could include a psychiatrist, nurse, substance abuse specialist. For reporting purposes, there should be at least 3 FTE on the team
- Includes clinical component: In addition to case management, the program directly provides services such as: psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.
- Services provided in community settings: Program works to monitor status, develop community living skills in the community rather than the office.
- Responsibility for crisis services: Program has 24-hour responsibility for covering psychiatric crises.

IV. ACT IS NOT INTENSIVE CASE MANAGEMENT

Note: If specific EBPs are provided as a component of ACT, they should be reported under ACT and not separately under other practices. In the revised version of the tables, please check off the EBPs that are provided under ACT. (Please note that to report these as EBPs; they should conform to the reporting guidelines for each EBP provided in this document.)

SUPPORTED EMPLOYMENT

I. DEFINITION

Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illnesses. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED EMPLOYMENT

- Competitive employment: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status. Employment is competitive so that potential applicants include persons in the general population.

- Integration with treatment: Employment specialists are part of the mental health treatment teams with shared decision making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.

- Rapid job search: The search for competitive jobs occurs rapidly after program entry.

- Eligibility based on consumer choice (not client characteristics): No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms.

- Follow–along support: Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Employer supports may include education and guidance. Client supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and, networked supports (friends/family).

IV. **SUPPORTED EMPLOYMENT IS NOT**:

- Prevocational training
- Sheltered work
- Employment in enclaves (that is in settings, where only people with disabilities are employed)
- [If an employment specialist is part of an ACT team, this should be reported under ACT and not separately as supported employment.]

SUPPORTED HOUSING

I. DEFINITION

Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assists clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

II. FIDELITY MEASURE (Not currently available)

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED HOUSING

- Target population: Targeted to persons who would not have a viable housing arrangement without this service.
- Staff assigned: Specific staff are assigned to provide supported housing services.
- Housing is integrated: That is, supported housing provided for living situations in settings that are also available to persons who do not have mental illnesses.
- Consumer has the right to tenure: The ownership or lease documents are in the name of the consumer.
- Affordability: Supported housing assures that housing is affordable (consumers pay no more than 30-40% on rent and utilities) through adequate rent subsidies, etc.

IV. SUPPORTED HOUSING IS NOT:

- Residential treatment services.
- A component of case management or ACT.

FAMILY PSYCHO-EDUCATION

I. DEFINITION

Family psycho-education is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psycho-education programs may be either multi-family or single-family focused. Core characteristics of family psycho-education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/

III. MINIMUM REQUIREMENTS FOR REPORTING FAMILY PSYCHO-EDUCATION

- A structured curriculum is used.
- Psycho-education is a part of clinical treatment.

IV. FAMILY PSYCHO-EDUCATION IS NOT:

Several mechanisms for family psycho-education exist. The evidence-based model, promoted through SAMHSA's EBP implementation resource kit ("toolkit") involves a clinician. For DIG reporting, do not include family psycho-education models not involving a clinician as part of clinical treatment.

Note: Some states are providing NAMI's Family-to-Family program and not the family psycho-education EBP described above. If a state is providing NAMI's Family-to-Family program, this should be reported under family psycho-education with an asterisk and a note indicating that the numbers reflect the NAMI program and not the EBP described above.

INTEGRATED TREATMENT FOR CO-OCCURRING DISORDER
(MENTAL HEALTH / SUBSTANCE ABUSE)

I. DEFINITION

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/

III. MINIMUM REQUIREMENTS FOR REPORTING INTEGRATED TREATMENT

- Multidisciplinary team: A team of clinical, working in one setting provides MH and SA interventions in a coordinated fashion.
- Stagewise interventions: That is, treatment is consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)

IV. INTEGRATED TREATMENT IS NOT:

- Coordination of clinical services across provider agencies

ILLNESS MANAGEMENT / RECOVERY

I. DEFINITION

Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness, strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/

III. MINIMUM REQUIREMENTS FOR REPORTING ILLNESS MANAGEMENT & RECOVERY

- Service includes a specific curriculum that includes mental illness facts, recovery strategies, using medications, stress management and coping skills. It is critical that a specific curriculum is being used for these components to be counted for reporting.

IV. EVIDENCE-BASED ILLNESS MANAGEMENT IS NOT:

- Advice related to self-care but a comprehensive, systematic approach to developing an understanding and a set of skills that help a consumer be an agent for his or her own recovery.

MEDICATION MANAGEMENT

I. DEFINITION

In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcome are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/

III. MINIMUM REQUIREMENTS FOR REPORTING MEDICATION MANAGEMENT

- Treatment plan specifies outcome for each medication.
- Desired outcomes are tracked systematically using standardized instruments in a way to inform treatment decisions.
- Sequencing of antipsychotic medication and changes are based on clinical guidelines.

IV. EVIDENCE-BASED MEDICATION MANAGEMENT IS NOT:

- Medication prescription administration that occurs without the minimum requirements specified above.

MULTISYSTEMIC THERAPY (MST)

I. DEFINITION

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.

II. FIDELITY MEASURE (Contact Jeanne Rivard at 703-682-9468 or Jeanne.rivard@nri-inc.org .

III. MINIMUM REQUIREMENTS

- Services take into account the life situation and environment of the child / adolescent and involve peers, school staff, parents, etc.
- Services are individualized
- Services are provided by MST Therapists or masters-level professional
- Services are time-limited
- Services are available 24/7

THERAPEUTIC FOSTER CARE

I. DEFINITION

Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed."

II. FIDELITY MEASURE (Contact Jeanne Rivard at 703-682-9468 or Jeanne.rivard@nri-inc.org)

III. MINIMUM REQUIREMENTS FOR REPORTING

- There is an explicit focus on treatment
- There is an explicit program to train and supervise treatment foster parents
- Placement is in the individual family home

IV. THERAPEUTIC FOSTER CARE IS NOT:

- An enhanced version of regular foster care.

FUNCTIONAL FAMILY THERAPY (FFT)

I. DEFINITION

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

II. FIDELITY MEASURE (Contact Jeanne Rivard at 703-682-9468 or Jeanne.rivard@nri-inc.org)

III. MINIMUM REQUIREMENTS

- Services are provided in phases related to engagement, motivation, assessment, behavior change, etc.
- Services are short-term, ranging from 8-26 hours of direct service time
- Flexible delivery of service by one and two person teams to clients in-home, clinic, juvenile court, and at time of re-entry from institutional placement.